Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgement before publication.

Pelvic Pain Cured by Pelvic Examination

TO THE EDITOR: I recently read Sargent's interesting report about three cases of pelvic pain apparently cured by pelvic examination,[1] and suggest two nonpsychogenic causes of his three patients' pain.

One possible cause is ovulation: a graafian follicle rupturing from the ovarian surface into the peritoneal cavity (either through the assistance of examination or coincidentally at that moment) would relieve local pressure on the overlying peritoneum. Additional information on the patients' menstrual phases might readily exclude this hypothesis, or offer some support.

Another possibility is rupture of a paratubal cyst, again either spontaneously or through manipulation; such cysts are extremely common incidental findings both in surgical specimens of fallopian tubes removed for other reasons and at autopsy, and usually are clinically silent. Perhaps the patients in the cases reported had oversized cysts of this type, producing pain by stretching of overlying visceral peritoneum; the extraordinarily thin, transparent walls of such cysts break easily with handling, draining their contents and wrinkling their decompressed surfaces. The serous contents of such cysts, like those of follicles, might enter a fallopian tube via fimbriae, and might elicit no peritoneal reaction.

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REFERENCE

1. Sargent E: Unusual pelvic pain apparently cured by pelvic examination (Correspondence). West J Med 1980 Jul; 133:80

Carcinoma as a Possible Complication of Jejunoileal Bypass Operation

TO THE EDITOR: Since the first intestinal bypass for obesity was carried out in 1956, multiple complications have been reported. These include electrolyte and metabolic abnormalities, predisposition to fungal infections, hepatic and renal failure. Although intestinal sequelae of bypass operations are quite common, they have received far less attention. Frequently, patients will present with severe diarrhea postoperatively. This is commonly associated with anorectal pain, itching and burning. These symptoms have been shown to persist for as long as three years in bypass patients.[1] External hemorrhoidal thrombosis, anal fissures, abscesses, rectal inflammation and bleeding have been found on physical examination. There has been, however, no previous report of anal carcinoma in a bypass patient. Such a finding is the basis of this correspondence.

Report of a Case

The patient is a 44-year-old woman with a long history of obesity refractory to conservative management who underwent jejunoileal bypass with end-to-end anastomosis in February 1975. The anastomosis was revised because of inadequate weight loss in May 1976, leaving 46 cm (18 in) of small intestine in continuity. The long blind limb was anastomosed to the sigmoid colon in an end-to-side fashion. Weight loss ensued with three to five liquid movements per day.

In December 1982, the patient presented with symptoms of anorectal pain and bleeding. Repeat outpatient evaluations apparently did not give any specific findings other than "hemorrhoids." In April 1983, because of severe rectal pain, the patient was admitted to hospital and numerous evaluations were done, including digital rectal examination, sigmoidoscopy and barium enema. A definitive diagnosis was not made. The patient referred herself to us because of persistent bleeding and pain in July 1983, and at that time, on rectal examination done following intravenous injection of diazepam, a mass was palpated in the rectum and upper portion of the anus, which on biopsy was moderately well-differentiated squamous-cell carcinoma. In addition, a pelvic mass was appreciated. A computed tomographic scan showed a soft-tissue pelvic mass as well as thickening of the rectum. A bone scan showed no abnormalities.

At exploration, the tumor was found to extend into the bladder. A radical abdominoperineal resection with removal of a portion of the bladder and uterus was carried out. Pathologic evaluation showed squamous-cell carcinoma with 3 of 13 lymph nodes positive for tumor. The patient subsequently received adjuvant radiotherapy.

Jejunoileal bypass patients commonly have anorectal complaints. Some patients, however, are so exquisitely tender that the physician is unable to do a thorough office examination. In these instances, examination under anesthesia and sedation becomes requisite. This case illustrates the error in attributing distressing symptoms such as rectal pain and bleeding to simple hemorrhoids. It is critical that a careful examination of the anus and rectum be performed.

Squamous-cell carcinoma is not usually expected in a 44-year-old patient. Although the occurrence of carcinoma in this patient could well be coincidental, a number of hypotheses might explain a causal relationship between intestinal bypass and the genesis of carcinoma. The purpose of the operation is to induce malabsorption. This change delivers